	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		A. BUILDING		A. BUILDING:		
		MHL041-538	B. WING		12	2/14/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
OBSON	ROAD HOME		BSON ROAD SBORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	3	V 000			
	on 12/14/2021. The c	laint survey was completed complaint was substantiated Deficiencies were cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.				
	The survey sample c current clients.	onsisted of audits of 3				
V 291	27G .5603 Supervised Living - Operations		V 291			
	six clients when the of developmental disability on June 15, 2001, and than six clients at that provide services at in- licensed capacity. (b) Service Coordinat maintained between qualified professionat treatment/habilitation (c) Participation of the Responsible Person, provided the opportu- relationship with her means as visits to the the facility. Reports a annually to the parent legally responsible per Reports may be in we conference and shall progress toward meet (d) Program Activitie	ity shall serve no more than clients have mental illness or ilities. Any facility licensed of providing services to more at time, may continue to o more than the facility's ation. Coordination shall be the facility operator and the ls who are responsible for or case management. he Family or Legally Each client shall be nity to maintain an ongoing or his family through such e facility and visits outside shall be submitted at least t of a minor resident, or the erson of an adult resident. riting or take the form of a focus on the client's eting individual goals. s. Each client shall have based on her/his choices,				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		MHL041-538	B. WING		12	2/14/2021
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
OBSON	ROAD HOME		BSON ROAD SBORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From page	e 1	V 291			
	Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination with the qualified professionals responsible for treatment/habilitation affecting 1 of 3 audited clients (#1). The findings are:					
	revealed: - Admission date: 10, - Diagnoses: Profour epilepsy; Moyamoya disease that affects t brain); osteoporosis; disorder of the blood fingers and toes that narrow when you are history of internal and benign essential hypertermity contracture constipation; hyperop	Ind Intellectual Disability; Disease (a rare progressive he blood vessels in the Raynaud's Disease (a rare vessels usually in the causes the blood vessels to e cold or feeling stressed); d external carotid surgery; ertension; upper and lower es; muscle spasms; bia (far-sightedness); mited right visual field; history nd Cerebral Palsy. home visit to attend a				
	Interview attempt on - He was minimally v details about his rece Interview on 12/10/20 revealed:	12/7/20212 revealed: erbal and unable to provide ent exposure to COVID-19. D21 with Client #1's Guardian otal physical care, could only				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
			A. BOILDING.			
		MHL041-538	B. WING		1:	2/14/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
OBSON	ROAD HOME		BSON ROAD SBORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From page	e 2	V 291			
	<ul> <li>provide details about</li> <li>She had requested</li> <li>Client #1 for a home</li> <li>Thanksgiving gatherii</li> <li>Client #1 returned to</li> <li>gathering on the same</li> <li>On Sunday, 11/28/2</li> <li>another attendee at the</li> <li>for COVID-19.</li> <li>Client #1 had been</li> <li>other attendee at the</li> <li>The majority of the and tested positive for</li> <li>She had contacted</li> <li>(FHM) on 11/28/2021</li> <li>possible exposure.</li> <li>On Monday, 11/29/2</li> <li>Client #1 to ride the tested program.</li> <li>The transportation swere not notified of the and tested program.</li> <li>The transportation swere not notified of the and the day program has because the facility swith the day program for the spoke to the Quint/29/2021, and he did having been exposed</li> <li>The FHM had worked years, and she did not have allowed the incident of the sport of the form of the</li></ul>	that the facility transport visit in order to attend a ng on Thursday, 11/25/2021. to the facility after the re day. 2021 she found out that he gathering tested positive in a different room than the gathering. attendees at the gathering or COVID-19 later. the Former House Manager in order to inform her of the 2021, facility staff allowed ransportation bus to his day service and day program he possible exposure. ad to close for a week taff did not communicate ualified Professional (QP) on lid not know about Client #1 d to COVID-19. ed at the facility for many of think that the FHM would dent to occur intentionally.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		MHL041-538	B. WING		12	2/14/2021
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
OBSON	ROAD HOME		BSON ROAD			
			SBORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
V 291	Continued From pag	e 3	V 291			
	day.					
		n reported that she had told				
		anager (FHM) on 11/28/2021				
	that Client #1 may ha					
		•				
	positive for COVID-1	someone at a Thanksgiving gathering who tested				
	- No one from the facility had contacted the day					
	program to notify them of Client #1's exposure to					
	COVID-19.					
	- Because Client #1 I	- Because Client #1 had been sent to the day				
		program after exposure to someone with				
	COVID-19, the day program had to close for the					
	entire week.					
	- The closure of the day program impacted 23					
	total day program clients.					
	Interview on 12/7/202	Interview on 12/7/2021 with Staff #1 revealed:				
		ntly in quarantine due to				
	exposure to COVID-	19 on Thanksgiving Day,				
	11/25/2021.					
		aff had Ported Todd to the				
	Thanksgiving gatheri					
		med of Client #1's exposure				
	when she returned to	o work on Tuesday,				
	11/30/2021.					
		ssage to all of the staff on				
	-	them that Client #1 had				
	-	VID-19 and needed to be				
	quarantined.					
	Interviews on 12/7/20	021 and 12/10/2021 with				
	Staff #2 revealed:					
	- He worked on 3rd s	shift at the facility				
		Client #1's exposure to				
	COVID-19 on Monda					
		s exposed to COVID-19, the				
		f told the direct care staff				
	what to do.					
		the facility was "kind of rough				
		e was not currently a House				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-538 B. WING				
					12/14/20	
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
OBSON	ROAD HOME		BSON ROAD BBORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From page	e 4	V 291			
	Manager working the	facility.				
	<ul> <li>Her final day workin was on 12/4/2021.</li> <li>She was currently w facilities.</li> <li>She had been work when Client #1's Gua inform her that he ma someone who later te - Client #1's Guardian her that Client #1 had than the person who</li> <li>She had left a mess call staff to inform the received a call back.</li> <li>She had left a mess call staff to inform the received a call back.</li> <li>She had informed 3 possible COVID-19 e ended that evening.</li> <li>She did not know th to his day program or after he had already s</li> <li>When she called the that he had already h Guardian about the O - She thought the mix Client #1 and not sen on Monday, 11/29/20 result of confusion ab actually been directly</li> <li>She acknowledged on top of it more."</li> </ul>	age for the Licensee's on em of the exposure but never rd shift of Client #1's exposure when her shift nat Client #1 had been sent n Monday, 11/29/2021 until sent. e QP on Monday, he said leard from Client #1's COVID-19 exposure. c up about quarantining riding him to his day program 21, may have been the bout whether Client #1 had				
		tepped down from her e position at sister facilities.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
MHI 041-538			A. BUILDING:		-	
		MHL041-538	B. WING		12	/14/2021
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
OBSON	ROAD HOME		BSON ROAD SBORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From page	e 5	V 291			
	<ul> <li>11/15/2021.</li> <li>He did not find out a someone who tested he received a call fro Monday, 11/29/2021.</li> <li>When he learned of facility staff to pick Cl program.</li> <li>The FHM should ha learned of the expose.</li> <li>Prior to this incident issues with the FHM's Interview on 12/14/20 Nurse revealed:</li> <li>She had been on ca Thanksgiving.</li> <li>She had not receive Client #1 having been en that the shown of the that the would not have been quarantine and he would not have been that the shown.</li> </ul>	the exposure, he sent ient #1 up from his day we contacted him when she ure. t, he was not aware of any				
	notified when the FH exposure to COVID- - Nursing staff would					
V 540	27F .0103 Client Rigl Grooming	nts - Health, Hygiene And	V 540			
	10A NCAC 27F .0103 AND GROOMING	B HEALTH, HYGIENE				

STATEMENT	of Health Service Regu TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
and plan (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	PLETED
		MHL041-538	B. WING		12	2/14/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
DOBSON	ROAD HOME		BSON ROAD SBORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 540	Continued From pag	e 6	V 540			
	dignity, privacy and h of personal health, hy Such rights shall incl to the: (1) opportunity daily, or more often a (2) opportunity (3) opportunity barber or a beauticia (4) provision of paper and soap for e individual personal h indigent client. Such not limited to toothpa napkins, tampons, sh utensil. (b) Bathtubs or show individual privacy sha (c) Adequate toilets,	to shave at least daily; to obtain the services of a n; and f linens and towels, toilet ach client and other ygiene articles for each other articles include but are aste, toothbrush, sanitary having cream and shaving vers and toilets which ensure all be available. lavatory and bath facilities a client with a mobility				
	facility failed to assur humane care in the p	ews and interviews, the re the right to dignity and provision of personal health, ng affecting 1 of 3 audited				
	revealed: - Admission date: 10, - Diagnoses: Profour epilepsy; Moyamoya disease that affects t	l of Client #1's record /9/2000 nd Intellectual Disability; Disease (a rare progressive he blood vessels in the Raynaud's Disease (a rare				

Division of Health Service Regulation STATE FORM

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If continuation sheet 7 of 10

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-538	B. WING		12/14/	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
OBSON	ROAD HOME		BSON ROAD BORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 540	Continued From page	e 7	V 540			
	fingers and toes that narrow when you are history of internal and benign essential hype extremity contracture constipation; hyperop seasonal allergies; lir of multiple strokes; a Review on 12/14/202 Client #1's Day Prog - Client #1 had arrive dried urine and/or feo 8/30/2021, 10/15/202 11/8/2021, 11/9/2021 - Client #1's nails and on 10/21/2021.	bia (far-sightedness); mited right visual field; history nd Cerebral Palsy. 21 of progress notes from ram revealed: d at the day program with ces in his diaper on 21, 10/25/2021, 11/4/2021, and 11/10/2021. d hair were poorly groomed 12/7/20212 revealed: erbal and unable to provide				
	revealed: - Client #1 required to speak about ten word provide details about - The Former House giving Client #1 a cre was no longer workin - Client #1 needed to day. - Over the past month full of dandruff. - Client #1 had a Hoy	Manager (FHM) had been w cut every month, but she				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED 12/14/2021	
		MHL041-538	B. WING			
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
OBSON	ROAD HOME		BSON ROAD BORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 540	Continued From pag	e 8	V 540			
	had arrived at the da diapers. - Client #1's nails and on several occasions - Client #1's hair was - The facility had a no (QP), but the day pro- contact with him. - There had not been grooming when the p facility. Interview on 12/7/202 - Client #1 required h needs. - 3rd shift normally ga - Client #1's hair was had a prescription sh - Nail care was done - There had not been	veral occasions that Client #1 y program with soiled d hair had not been cared for a as well. very oily. ew Qualified Professional ogram had not had any any issues with Client #1's previous QP had been at the 21 with Staff #1 revealed: hands on care for all of his ave Client #1 his shower. washed daily because he hampoo he had to use. every Tuesday. every Wednesday. any issues with Client #1's				
	Staff #2 revealed: - He usually worked = - 1st and 2nd shifts w #1 a bath. - 3rd shift staff would and get him ready to mornings. - The FHM used to c probably been 2 or 3 received a hair cut. - 2nd shift was suppor and complete his nai	021 and 12/10/2021 with 3rd shift. vere supposed to give Client "wipe him (Client #1) down" go to his day program in the ut Client #1's hair, but it had weeks ago when he last osed to wash Client #1's hair				

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-538	B. WING		12	/14/2021
ME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
OBSON	ROAD HOME		BSON ROAD BORO, NC 27419			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
V 540	Continued From pag	e 9	V 540			
	<ul> <li>Client #1's nails we weekly.</li> <li>Client #1 was support have his hair washed.</li> <li>Facility staff had read during the past summing rooming and hygien.</li> <li>She had not heard #1's grooming or hyge Interview on 12/10/20 QP revealed:</li> <li>He had just taken of in early November.</li> <li>When he first went to facility staff about on ail care were done of the had not ben awas sent to the day program about the day pro</li></ul>	ceived in-service training ner about Client #1's ne needs. any complaints about Client giene. 021 and 12/14/2021 with the in the role of QP at the facility to the facility, he had talked ensuring that hair cuts and				